		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035048

Facility Name: Lake Shore Healthcare & Rehab Centre

Address: 7200 N. Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 973-7200 **Fax #** (773) 973-7724

IDPA ID Number: 36-3690679

Date of Initial License for Current Owners: 28-July-1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 28-Mar-2002 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	328	Skilled (SNF)	328	119,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,642	3,014	5,851	35,507	8
9	SNF/PED					9
10	ICF	54,949	4,621		59,570	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	81,591	7,635	5,851	95,077	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.42%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-March-1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 28-July-1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 182 and days of care provided 4,956

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	379,430	116,679	33,559	529,668		529,668		529,668			1
2	Food Purchase		549,174		549,174	(37,033)	512,141	(395)	511,746			2
3	Housekeeping	301,856	97,888		399,744		399,744		399,744			3
4	Laundry	158,740	43,416		202,156		202,156		202,156			4
5	Heat and Other Utilities			272,728	272,728		272,728		272,728			5
6	Maintenance	125,612	64,272	102,265	292,149		292,149	5,466	297,615			6
7	Other (specify):*											7
8	**TOTAL General Services**	965,638	871,429	408,552	2,245,619	(37,033)	2,208,586	5,071	2,213,657			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,736,609	320,797	61,971	4,119,377		4,119,377		4,119,377			10
10a	Therapy			34,155	34,155		34,155		34,155			10a
11	Activities	163,268	26,398		189,666		189,666		189,666			11
12	Social Services	167,016	1,301		168,317		168,317		168,317			12
13	Nurse Aide Training			9,700	9,700		9,700		9,700			13
14	Program Transportation											14
15	Other (specify):* *Dental Service**			8,137	8,137		8,137		8,137			15
16	**TOTAL Health Care and Programs**	4,066,893	348,496	152,963	4,568,352		4,568,352		4,568,352			16
	C. General Administration											
17	Administrative	183,543		476,400	659,943		659,943	(270,765)	389,178			17
18	Directors Fees											18
19	Professional Services			22,651	22,651		22,651	29,307	51,958			19
20	Dues, Fees, Subscriptions & Promotions			120,738	120,738		120,738	(82,126)	38,612			20
21	Clerical & General Office Expenses	356,828	54,647	95,512	506,987		506,987	148,361	655,348			21
22	Employee Benefits & Payroll Taxes			831,066	831,066	37,033	868,099	61,298	929,397			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,446	8,446		8,446	524	8,970			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			121,094	121,094		121,094	726	121,820			26
27	Other (specify):*							37,171	37,171			27
28	**TOTAL General Administration**	540,371	54,647	1,675,907	2,270,925	37,033	2,307,958	(75,504)	2,232,454			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,572,902	1,274,572	2,237,422	9,084,896		9,084,896	(70,433)	9,014,463			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre #0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			82,924	82,924		82,924	328,224	411,148			30
31	Amortization of Pre-Op. & Org.							10,895	10,895			31
32	Interest			25,145	25,145		25,145	757,840	782,985			32
33	Real Estate Taxes			404,205	404,205		404,205		404,205			33
34	Rent-Facility & Grounds			2,405,883	2,405,883		2,405,883	(2,400,000)	5,883			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,918,157	2,918,157		2,918,157	(1,303,041)	1,615,116			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		226,822	83,297	310,119		310,119		310,119			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,580	179,580		179,580		179,580			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		226,822	262,877	489,699		489,699		489,699			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,572,902	1,501,394	5,418,456	12,492,752		12,492,752	(1,373,474)	11,119,278			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,312)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(395)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,159)	21		24
25	Fund Raising, Advertising and Promotional	(98,107)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,529)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule **Deferred Maintenance Cost**	(1,051)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (170,553)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,202,921)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,202,921)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,373,474)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lake Shore Healthcare & Rehab Centre

ID# 0035048

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost	$ (1,051)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,051)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(395)	0	0	0	0	0	0	0	0	0	0	(395)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,051)	6,517	0	0	0	0	0	0	0	0	0	5,466	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,446)	6,517	0	0	0	0	0	0	0	0	0	5,071	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(275,765)	5,000	0	0	0	0	0	0	0	0	(270,765)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,917	390	0	0	0	0	0	0	0	0	29,307	19
20	Fees, Subscriptions & Promotions	(98,107)	15,981	0	0	0	0	0	0	0	0	0	(82,126)	20
21	Clerical & General Office Expenses	(26,688)	175,049	0	0	0	0	0	0	0	0	0	148,361	21
22	Employee Benefits & Payroll Taxes	0	61,298	0	0	0	0	0	0	0	0	0	61,298	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	524	0	0	0	0	0	0	0	0	0	524	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	726	0	0	0	0	0	0	0	0	0	726	26
27	Other (specify):*	0	37,171	0	0	0	0	0	0	0	0	0	37,171	27
28	**TOTAL General Administration**	(124,795)	43,901	5,390	0	0	0	0	0	0	0	0	(75,504)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(126,241)	50,418	5,390	0	0	0	0	0	0	0	0	(70,433)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre **#** 0035048 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(44,312)	2,107	370,429	0	0	0	0	0	0	0	0	328,224	30
31	Amortization of Pre-Op. & Org.	0	0	10,895	0	0	0	0	0	0	0	0	10,895	31
32	Interest	0	61,319	696,521	0	0	0	0	0	0	0	0	757,840	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,400,000)	0	0	0	0	0	0	0	0	(2,400,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(44,312)	63,426	(1,322,155)	0	0	0	0	0	0	0	0	(1,303,041)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(170,553)	113,844	(1,316,765)	0	0	0	0	0	0	0	0	(1,373,474)	45

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Salary-Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 160,385	$ 160,385	1
2	V	27	Payroll Taxes		Lancaster, Ltd.	100.00%	37,171	37,171	2
3	V	17	Management Fee Income	476,400	Lancaster, Ltd.	100.00%		(476,400)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	28,917	28,917	4
5	V	21	Office Expenses		Lancaster, Ltd.	100.00%	175,049	175,049	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	61,298	61,298	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	524	524	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	40,250	40,250	8
9	V	20	Fees and Marketing		Lancaster, Ltd.	100.00%	15,981	15,981	9
10	V	32	Interest	25,145	Lancaster, Ltd.	100.00%	86,464	61,319	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	2,107	2,107	11
12	V	26	Professional Liability Ins.		Lancaster, Ltd.	100.00%	726	726	12
13	V	6	Maintenance		Lancaster, Ltd.	100.00%	6,517	6,517	13
14	Total			$ 501,545			$ 615,389	$ * 113,844	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental Income	$ 2,400,000	Lake Shore Associates	100.00%	$	$ (2,400,000)	15
16	V	30	Depreciation		Lake Shore Associates	100.00%	370,429	370,429	16
17	V	31	Amortization		Lake Shore Associates	100.00%	10,895	10,895	17
18	V	17	Administrative Consultant		Lake Shore Associates	100.00%	5,000	5,000	18
19	V	19	Accounting Services		Lake Shore Associates	100.00%	390	390	19
20	V	32	Interest	55,626	Lake Shore Associates	100.00%	752,147	696,521	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,455,626			$ 1,138,861	$ * (1,316,765)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	50.00%	See Attached	30	37.50%	Lancaster	$ 55,385	17-7	1
2	Laurence Zung	Officer	Administrative	50.00%	See Attached	14	29.17%	Lancaster	105,000	17-7	2
3	Julie Chow	Asst. Administrator	Administrative	0.00%	None	40	100%	Reg. Salary	45,855	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 206,240		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL. 60630
Phone Number: (773) 478-3699
Fax Number: (773) 478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 120,000	$ 120,000	30	$ 55,385	1
2	27	Cynthia Chow	Hours Worked	65	7	6,835		30	3,155	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	14	105,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,315		14	3,009	4
5										5
6										6
7	19	Professional Services	Management Fees	1,697,900	7	103,061		476,400	28,917	7
8	21	Office Expenses	Management Fees	1,697,900	7	27,792		476,400	7,798	8
9	22	Employee Benefits	Management Fees	1,697,900	7	218,469		476,400	61,298	9
10	24	Education and Seminars	Management Fees	1,697,900	7	1,868		476,400	524	10
11	17	Administrative Consultant	Management Fees	1,697,900	7	143,451		476,400	40,250	11
12	20	Marketing	Management Fees	1,697,900	7	54,625		476,400	15,327	12
13	32	Interest	Management Fees	1,697,900	7	109,907		476,400	30,838	13
14	30	Depreciation	Management Fees	1,697,900	7	7,511		476,400	2,107	14
15	26	Professional Liability Ins.	Management Fees	1,697,900	7	2,588		476,400	726	15
16	20	Licenses and Fees	Management Fees	1,697,900	7	2,330		476,400	654	16
17	6	Maintenance	Management Fees	1,697,900	7	23,228		476,400	6,517	17
18	21	Salary-Clerical	Management Fees	1,697,900	7	596,087	596,087	476,400	167,251	18
19	27	P/R Taxes-Clerical	Management Fees	1,697,900	7	110,511		476,400	31,007	19
20										20
21	32	Direct Interest							55,626	21
22										22
23										23
24										24
25	TOTALS					$ 1,898,578	$ 1,076,087		$ 615,389	25

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Aid Association Lutheran		X	Mortgage	$93,608.00	7/28/92	$ 9,700,000	$ 7,349,734	8/01/2012	10.00%	$ 752,147	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X		Working Capital							30,838	6
7												7
8												8
9	TOTAL Facility Related				$93,608.00		$ 9,700,000	$ 7,349,734			$ 782,985	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,700,000	$ 7,349,734			$ 782,985	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	434,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	416,205	2
3. Under or (over) accrual (line 2 minus line 1).	$	(17,795)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	422,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	404,205	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	418,151	8
	1997	421,635	9
	1998	429,119	10
	1999	426,240	11
	2000	416,205	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035048

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-320-040-0000	Long-Term Healthcare	$ 25,537.86	$ 25,537.86
2.	11-29-320-039-0000	Long-Term Healthcare	$ 91,160.25	$ 91,160.25
3.	11-29-320-037-0000	Long-Term Healthcare	$ 91,310.33	$ 91,310.33
4.	11-29-320-038-0000	Long-Term Healthcare	$ 91,310.33	$ 91,310.33
5.	11-29-320-036-0000	Long-Term Healthcare	$ 90,930.59	$ 90,930.59
6.	11-29-320-035-0000	Long-Term Healthcare	$ 25,955.22	$ 25,955.22
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 416,204.58	$ 416,204.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

** NONE **

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 217,904
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 10,895
4. Dates Incurred: 28-July-1992

Nature of Costs: Pre-Operating Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1992	$ 740,000	1
2					2
3	TOTALS			$ 740,000	3

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	328		1992		$ 11,667,460	$ 370,396	40	$ 291,687	$ (78,709)	$ 2,771,027	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	24,908		10			24,908	9
10	Various			1990	80,814		10			80,814	10
11	Various			1991	28,469	905	20	1,487	582	18,237	11
12	Various			1992	12,856	408	20	643	235	6,071	12
13	Various			1993	68,862	1,789	20	3,444	1,655	29,269	13
14	Various			1994	5,698	146	20	286	140	2,235	14
15	Various			1995	76,433	1,767	20	3,822	2,055	25,644	15
16	Fire Alarm System			1996	54,450	1,396	20	2,723	1,327	16,338	16
17	Seamco Stone Deck			1996	7,989	205	20	399	194	2,128	17
18	Roof Exhauster			1996	2,700	69	20	135	66	697	18
19	Front Sign			1996	12,020	779	20	601	(178)	3,155	19
20	Water Heating System			1997	38,800	995	20	1,940	945	9,377	20
21	Fluorescent Conversion			1997	25,353	650	20	1,268	618	6,023	21
22	Elevator Improvement			1998	55,364	1,420	20	1,420		5,148	22
23	Electronic Alzheimer Doors			1998	11,800	303	20	303		997	23
24	Elevator Interiors			1999	34,422	883	20	883		2,097	24
25	Parking Lot Resurface			1999	20,240	1,799	20	1,799		4,051	25
26	Patio Stone Decking			1999	6,465	560	20	560		1,425	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,235,103	$ 384,470		$ 313,400	$ (71,070)	$ 3,009,641	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,849,832	$ 58,660	$ 80,804	$ 22,144		$ 1,272,257	71
72	Current Year Purchases	63,068	12,330	12,330			12,330	72
73	Fully Depreciated Assets	264,310		4,614	4,614		264,310	73
74								74
75	TOTALS	$ 2,177,210	$ 70,990	$ 97,748	$ 26,758		$ 1,548,897	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,152,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 455,460	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 411,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (44,312)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,558,538	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ** N/A - Related Party Lease **

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		*** Off-site Public Storage space***			5,883			5
6								6
7	TOTAL				$ 5,883 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 32

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		9,700		9,700
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 9,700	$	$ 9,700
10	SUM OF line 9, col. 1 and 2 (e)	$ 9,700			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	
TOTAL TRAINED	23

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 14,676	$		$ 14,676	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,039			3,039	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			21,876			21,876	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				185,150		185,150	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-3				8,159			8,159	12
13	** Inhalation/Ventilation Therapy **	39-3				35,547			35,547	
	Other (specify): Med.Sup/Sp.Bed Rent	39-2					41,672		41,672	13
14	TOTAL			$		$ 83,297	$ 226,822		$ 310,119	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,791	$ 9,917	1
2	Cash-Patient Deposits	97,025	97,025	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,053,895	3,053,895	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,276	67,276	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	59,182	259,848	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,284,169	$ 3,487,961	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		740,000	13
14	Buildings, at Historical Cost		11,667,460	14
15	Leasehold Improvements, at Historical Cost	529,251	529,251	15
16	Equipment, at Historical Cost	912,449	2,184,728	16
17	Accumulated Depreciation (book methods)	(940,956)	(5,716,564)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		217,904	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(102,596)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 500,744	$ 9,520,183	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,784,913	$ 13,008,144	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,875	$ 209,875	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	131,949	131,949	28
29	Short-Term Notes Payable	792,933	791,478	29
30	Accrued Salaries Payable	533,534	533,534	30
31	Accrued Taxes Payable (excluding real estate taxes)	72,411	72,411	31
32	Accrued Real Estate Taxes(Sch.IX-B)	422,000	422,000	32
33	Accrued Interest Payable		61,248	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,162,702	$ 2,222,495	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,349,734	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,349,734	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,162,702	$ 9,572,229	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,622,211	$ 3,435,915	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,784,913	$ 13,008,144	48

***(See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,046,726	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,046,726	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,515)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Treasury Stock	(185,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (424,515)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,622,211	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 35048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		Total After Consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,108,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,108,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,077,250	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Treasury Stock**	(550,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,672,750)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,435,915	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,555,425	1
2	Discounts and Allowances for all Levels	(797,863)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,757,562	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	203,999	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 203,999	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133,404	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,589	19
20	Radiology and X-Ray	3,855	20
21	Other Medical Services	130,596	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 285,444	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	*** Vending Commission ***	6,232	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,232	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,253,237	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,245,619	31
32	Health Care	4,568,352	32
33	General Administration	2,270,925	33
	B. Capital Expense		
34	Ownership	2,918,157	34
	C. Ancillary Expense		
35	Special Cost Centers	310,119	35
36	Provider Participation Fee	179,580	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,492,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,515)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,515)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **Cash Basis taxpayer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,908	2,174	$ 73,092	$ 33.62	1
2	Assistant Director of Nursing	2,282	2,530	77,175	30.50	2
3	Registered Nurses	69,880	74,886	1,597,359	21.33	3
4	Licensed Practical Nurses	9,758	10,808	192,393	17.80	4
5	Nurse Aides & Orderlies	166,745	177,847	1,701,236	9.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,678	3,027	36,570	12.08	9
10	Activity Assistants	11,793	12,508	126,698	10.13	10
11	Social Service Workers	13,291	14,589	167,016	11.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,974	41,780	379,430	9.08	15
16	Dishwashers					16
17	Maintenance Workers	9,021	10,245	125,612	12.26	17
18	Housekeepers	35,405	38,875	301,856	7.76	18
19	Laundry	20,223	22,160	158,740	7.16	19
20	Administrator	2,112	2,300	85,012	36.96	20
21	Assistant Administrator	3,761	4,091	98,531	24.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,937	24,150	356,828	14.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,026	7,753	95,354	12.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	416,794	449,723	$ 5,572,902 *	$ 12.39	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	1,033	$ 33,559	1-3	35
36	Medical Director	781	39,000	9-3	36
37	Medical Records Consultant	98	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	525	7,872	10-3	39
40	Physical Therapy Consultant	977	34,155	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,414	$ 118,618		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,019	$ 26,627	10-3	50
51	Licensed Practical Nurses	942	23,440	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,961	$ 50,067		53

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jim Farlee	Administrator	N/A	$ 85,012
Judy Lewis	Asst. Admin.	N/A	52,676
Julie Chow	Asst. Admin.	N/A	45,855
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 183,543

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 476,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 476,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 1,875
Richard Peelo	Accounting	2,250
Winston & Strawn	Legal	1,238
Panarese & Panarese	Legal	538
Sachnoff & Weaver	Legal	840
Power Software Development	Data Processing	3,450
RCN	Data Processing	1,501
Medi, Inc.	Data Processing	259
Sourcetech Computers	Data Processing	45
Health Data Systems, Inc.	Data Processing	9,665
Personnel Planners	Payroll Tax Consultant	990
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,651

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,788
Unemployment Compensation Insurance	32,692
FICA Taxes	419,530
Employee Health Insurance	242,758
Employee Meals	37,033
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	10,048
Misc. Employee Benefits	23,342
Retirement Plan Contributions	19,137
Uniform Allowance	12,881
Holiday expenses	3,116
Employment Fees	8,774
Lancaster Allocation	61,298
TOTAL (agree to Schedule V, line 22, col.8)	$ 929,397

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	16,848
Health Care Worker Background Check	492
(Indicate # of checks performed 41)	
Fingerprinting Checks	650
Promotional Advertising	82,126
Licenses & Fees	5,533
Dues & Subscription	14,889
Lancaster Allocation	15,981
Less: Public Relations Expense	(82,126)
Non-allowable advertising	(15,981)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,397
Seminar Expense	6,049
Lancaster Allocation	524
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,970

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting and Decorating	1996	$ 19,159	3	$ 6,386	$ 3,194	$	$	$	$	$	$	$
2	Painting and Decorating	Mar-97	2,805	3	935	935	468						
3	Painting and Decorating	Apr-97	5,116	3	1,705	1,705	853						
4	Painting and Decorating	Aug-97	3,270	3	1,090	1,090	545						
5	Painting and Decorating	Mar-98	3,052	3	509	1,017	1,017	509					
6	Painting and Decorating	Aug-2001	674	3				113	224	224	113		
7	Painting and Decorating	Dec-2001	1,199	3				200	400	400	199		
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 35,275		$ 10,625	$ 7,941	$ 2,883	$ 822	$ 624	$ 624	$ 312	$	$

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre **#** 0035048 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care - $ 13,464**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,777** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **179,580**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **37,033** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.